TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Plano

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-17-1233-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The time filing denial is erroneous based on the fact that treatment was knowingly authorized and medical records indicate the services performed matched the services authorized."

Amount in Dispute: $49,381.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regardless, the fact the requestor changed the codes on the bill and calls it in the DWC60 packet a "corrected UB", does not reset the 95 day submission requirement of Rule 133.20, nor does it meet the criteria of a request for reconsideration given in Rule 133.250. If Texas Mutual had received this bill it would have denied the bill absent timely bill submission. Concerning the 10/4/16 bill (Attachment 2), Texas Mutual received it 12/2/16. …it does not meet that requirement because the initial bill under Attachment 1 does not list the physical/occupational therapy G codes or code 27720. Thus, this is a new bill subject to the 95 day bill submission requirement of Rule 133.20. For this reason Texas Mutual decline to issue any payment."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18 – 19, 2016	Outpatient hospital services	$49,381.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.

4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. 28 Texas Administrative Code §133.250 sets out guidelines for reconsideration for payment of medical bills.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 197 – Precertification/authorization/notification absent
   - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers compensation state regulations/fee schedule requirements
   - 246 – This non-payable code is for required reporting only
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
   - 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 446 – This add-on code has been denied as the principal procedure was not billed
   - 616 – This code has a status Q APC indicator and is packaged into other AP C does that have been identified by CMS
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 631 – PT, OT, or SP code present without required non-payable code
   - 725 – Approved on network provider for Texas Star Network claimant per Rule 1305.153 (C)
   - 767 – Paid per O/P FG at 200%; implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G)
   - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract
   - 18 – Exact duplicate claim/service
   - 29 – The time limit for filing has expired
   - 224 – Duplicate charge
   - 731 – Per 133.20(B) provider shall not submit a medical bill after than the 95th day after the date the service
   - 754 – Not a request for reconsideration; does not include same billing codes, dos and/or dollar amount as original bill per Rule 133.250

Issues

1. What is the rule applicable to claim submission?
2. Are the carrier's denials supported?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The requestor is seeking additional reimbursement for $49,381.25 for outpatient hospital services rendered on January 18 – 19, 2016.

   The information submitted with the request for MFDR finds the following:

   - Creation date – January 28, 2016 for $49,381.19. This claim was processed by the carrier and a payment of $3,058.76 was made to the provider.

- Creation date – June 22, 2016 for $49,381.25. This claim had no indication of a submission date and no explanation of benefits.
- Creation date – October 4, 2016 for $49,381.25. This claim had no indication of a submission date and no explanation of benefits.
- Request for reconsideration dated December 2, 2016 with the statement, "See attached Corrected UB/EOB and Letter of Reconsideration. NEW UB replaced CPT code 27536 with code 27720 the correct procedure for service rendered.
- Explanation of benefits from the carrier dated December 27, 2016 with denial codes 18 – "Duplicate charge" and 29 – "The time limit for filing has expired."

The requestor states, "Instead the UB denied for duplicate charges which it is evident that the bill was corrected. The time filing denial is erroneous…"

The respondent states, "this is a new bill subject to the 95 day bill submission requirement of Rule 133.20."

Therefore, as both positions relate to timely submission of a claim, this review will be made per the applicable Division rule (s) that determine the timely filing of claims found in 28 Texas Administrative Code 133.20.

2. 28 Texas Administrative Code 133.20 states in pertinent parts,

> (b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.
>
> (f) Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

Based on the requestor's position statement a "corrected" bill with a new code was submitted on December 2, 2016. Per the above Division rules, the denial of this claim as 18 – "Duplicate charge" and 29 – "The time limit for filing has expired" is supported as the 95th day from the date of service was Friday, April 22, 2016.

Texas Labor Code §408.0272(b) provides that:

> Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
> (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
> (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
> (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
> (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
> (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

3. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

> Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

(1) the date received, if sent by fax, personal delivery or electronic transmission or,
(2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds insufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.